

# **EXHIBIT 22**

IN THE UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

RICHARD KATZ

v.

NATIONAL BOARD OF MEDICAL  
EXAMINERS and FEDERATION OF  
STATE MEDICAL BOARDS

CIVIL ACTION

NO. 3:15-cv-1187

**AFFIDAVIT OF GERARD F. DILLON, PH.D.**

Gerard F. Dillon, having been duly sworn, hereby deposes and states:

1. My name is Gerard F. Dillon, and I am the Vice President for Licensure Programs at the National Board of Medical Examiners (NBME). I have worked at the NBME in various capacities since 1974. My curriculum vitae is attached. My background within psychology is psychometrics, which relates to the theory and technique of psychological measurement that focuses on the measurement of knowledge and skills.

2. I am providing this affidavit to share my knowledge about the United States Medical Licensing Examination ("USMLE") and the adoption, in 2011, by its Composite Committee, of a six-attempt limit on taking any Step or Step Component of the USMLE. The USMLE Composite Committee establishes policy for the USMLE Program and is composed of representatives of the Federation of State Medical Boards (FSMB), the National Board of Medical Examiners (NBME), the Educational Commission for Foreign Medical Graduates (ECFMG), and the American public. This affidavit is based on my personal knowledge gained from my role of providing information and support and participating as a staff person in the Composite Committee's meetings.

3. The USMLE is a three-step examination, assessing a physician's ability to apply knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills, that are important in health and the treatment of diseases, and that constitute the basis of safe and effective patient care. The USMLE is used by medical boards to evaluate applicants' minimum competence for purposes of medical licensure in the United States and its territories. Step 1 of the USMLE assesses whether the examinee understands and can apply important concepts of the core sciences basic to the practice of medicine, with special emphasis on principles and mechanisms underlying health, disease, and modes of therapy. Step 1 ensures mastery of not only the sciences that provide a foundation for the safe and competent practice of medicine in the present, but also the scientific principles required for maintenance of competence through lifelong learning.

4. Step 2 of the USMLE assesses whether the examinee can apply medical knowledge, skills, and understanding of clinical science essential for the provision of patient care under supervision, emphasizing health promotion and disease prevention. Step 2 is comprised of two parts: Step 2 CK (Clinical Knowledge) is constructed according to an integrated content outline that organizes clinical science material along two dimensions: physician task and disease category. Step 2 CS (Clinical Skills) is a clinical skills exam that uses standardized patients (actors in the role of patients) to test whether the examinee has the ability to gather information from patients, perform physical examinations, and communicate his or her findings to patients and colleagues.

5. Step 3 of the USMLE assesses whether the examinee can apply medical knowledge and understanding of biomedical and clinical science essential for the unsupervised practice of medicine, with emphasis on patient management in ambulatory settings. It is the final examination in the USMLE sequence leading to a license to practice medicine without supervision.

6. The examination material for all three steps of the USMLE is prepared by examination committees broadly representing the medical profession. The committees are comprised of recognized experts in their fields, including both academic and non-academic practitioners, as well as members of state medical licensing boards, which rely upon successful completion of the three USMLE steps as an important element in the process for licensing physicians.

7. Most medical schools in the United States and many located elsewhere require medical students to take USMLE Step 1 after completing the first two years of medical school, which is comprised of the core sciences that form the basis of medical practice.

8. I am aware that Richard Katz has alleged that before the adoption of the six-attempt limit in 2011, it had been the policy of the USMLE to allow examinees take a Step “as many times as they needed in order to pass.” That is a technically correct but misleading statement. The point was never to allow, and certainly not to encourage, an examinee with multiple failures on a Step or Step Component of the USMLE to continue taking the examination until he or she passed. The point was to place the responsibility for imposing attempt limits on state medical boards, rather than on the USMLE itself.

9. Before the adoption of the six-attempt limit by the USMLE through its Composite Committee, each individual state medical board decided for that state whether to impose an attempt limit on taking the USMLE, and if so, what the maximum number would be. The USMLE made recommendations to state medical boards about imposing attempt limits, including the recommendation – in place for nearly 20 years leading up to the adoption of the six-attempt limit – that state medical boards impose a limit of six attempts to pass any Step or Step Component unless the examinee demonstrated that he or she had obtained additional educational experience acceptable to the licensing authority.

10. In 2010-2011, when the Composite Committee considered adoption of a limit on the number of attempts to pass any Step or Step component of the USMLE, 41 out of 50 states (78%) imposed such limits. The vast majority imposed a limit of three or four attempts per Step. Pennsylvania was in the minority of states that imposed no attempt limit at all.

11. The primary impetus for the USMLE's consideration of a six-attempt limit was a security issue involving the computerized Steps of the USMLE, in which the concern was that examinees who took a Step multiple times might be contributing to the "leak" of examination questions.

12. A second significant motivation was the concern within the Composite Committee that among the very small percentage of examinees who repeatedly failed a Step of the USMLE, some might eventually pass not because of skill or knowledge, but by chance. The concern among the Committee was that an unqualified examinee might eventually pass by chance alone if given enough opportunities.

13. Throughout all the discussions of the Composite Committee that led to the adoption of the six-attempt limit, none of the participants expressed the concern that imposing a limit on the number of attempts might disproportionately impact individuals with disabilities, or that the limit itself might be discriminatory against individuals with disabilities.

14. In my opinion, based upon my participation in the discussions, the Composite Committee believed that the process at the NBME for evaluating and accommodating disabilities of USMLE examinees was sufficient and placed all examinees on the same footing, and that no additional measures were required specifically for disabled individuals in regard to the six-attempt limit.

15. In other words, those examinees who requested and received accommodations for their USMLE testing could utilize those accommodations during each attempt to pass a Step of the USMLE, whether the individual needed one attempt or six. Conversely, if an examinee who had been granted and utilized his or her accommodations was not held to the six-attempt limit like his or her non-disabled peers, it would create an unfair advantage for the disabled individual that is contrary to the intent of the disabilities laws.

16. The exception that the Composite Committee discussed, and adopted, was one that allows a state medical board to request an exception to the six-attempt limit for any specific examinee without regard to disability. In that way, just as before the adoption of the six-attempt limit, each state medical board could determine whether or not to impose attempt limits, and if so, the number of attempts permitted, so too, after the adoption of the six attempt limit, if a state medical board believed that an examinee should be given an additional attempt, the control would be with the state board who issues the license to practice medicine.

17. Since the adoption by the USMLE of the six-attempt limit, I am not aware of any evidence that leads me to believe that individuals with disabilities have been disproportionately impacted by the six-attempt limit, and I believe that if the six attempt limit were to be waived

or eliminated only for people with disabilities, it would create an unfair advantage for those individuals and would undermine the integrity of the examination.

18. Finally, I can attest without any equivocation that neither the USMLE Composite Committee nor the NBME had any intention to impact – positively or negatively – any category or group of examinees, including disabled individuals, when it considered and adopted the six-attempt limit. Rather, the USMLE Composite Committee adopted the six-attempt limit strictly for the reasons explained above.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE UNITED STATES OF AMERICA THAT THE FOREGOING IS TRUE AND CORRECT. EXECUTED ON THIS 2<sup>nd</sup> DAY OF May, 2016.

  
GERARD F. DILLON, PH.D.

# **EXHIBIT A**

## CURRICULUM VITAE

February 2016

Gerard F. Dillon, Ph.D.

### Business Address

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Philadelphia, PA 19104

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### Education

Ph.D., Educational Psychology, Temple University, 1992  
M.Ed., Educational Psychology, Temple University, 1980  
B.A., Psychology, LaSalle College, 1973

### Employment History

Vice President, Licensure Programs, 2013 to present  
National Board of Medical Examiners (NBME)

Responsible for coordination of activities related to licensure examinations, including those in support of USMLE. Responsibilities include implementation and coordination of policies, development of an appropriate program design, composition and activities of test committees, development of a research agenda, and liaison with external groups.

Vice President United States Medical Licensing Examination (USMLE) 2008 to 2013  
Associate Vice President, USMLE, 2001 to 2007  
Director, USMLE Step 3, NBME, 1997 to 2001  
Senior Psychometrician, NBME, 1980 to 2001  
Psychometric Associate, NBME, 1976 to 1980  
Psychometric Technician, NBME, 1974 to 1976  
Adjunct Faculty, Psychological Studies in Education, Temple University, 1995 to 1997

### Professional Organizations

Membership in: American Educational Research Association, (AERA)  
National Council on Measurement in Education (NCME)  
Administrators in Medicine (AIM)  
International Association of Medical Regulatory Authorities (IAMRA)

## Selected Presentations and Publications

Dillon, G.F., Henzel, T.R. and LaDuca, A. (1989). *The Use of Relative-Absolute Compromise Techniques in the Standard Setting Process*. Paper presented at the Annual Meeting of the National Council on Measurement in Education, April, San Francisco.

Dillon, G.F., Postell, L.E. and Henzel, T.R. (1990). *Using Scrambled Test Forms to Discourage Cheating Behavior - Practical Implications for Test Equating*. Paper presented at the Annual Meeting of the American Educational Research Association, April, Boston.

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Dillon, G.F., Nungester, R.J. and LaDuca, A. (1990). *The Relationship of Test Item Content and Format to Angoff Based Standard Setting Judgments - Alerting Judges to Potential Problems*. Paper presented at the Annual Meeting of the National Council on Measurement in Education, April, Boston.

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Clyman S.G., Julian E.R., Orr N.A., Dillon G.F., Cotton K.E.(1991). Continued research on computer-based testing. In Clayton PD (ed): *Proceedings of the Fifteenth Annual Symposium on Computer Applications in Medical Care*. New York, McGraw-Hill, Inc., pp 742-746.

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*Test Items Clustered Around Patient Cases - Psychometric Concerns and Practical Implications for a Medical Licensure Program.* Paper presented at the Annual Meeting of the American Education Research Association, April, Atlanta.

Dillon, G.F., Swanson, D.B., Nungester, R.J., Peskin, E., and Ross, L.P.(1993). *A System for Training Standard Setting Judges Using Repeated Exercises, Questionnaires, and Unique Data Formats.* Paper presented at the Annual Meeting of the American Educational Research Association, April, Atlanta.

Dillon, G.F.(1994). Setting Standards on Written Examinations. In Mancall, EL, Bashook, PG, and Dockery, JL (eds.): *Establishing Standards for Board Certification.* Evanston, American Board of Medical Specialties, pp. 41-45.

Dillon GF, Henzel TR, LaDuca A, Walsh, WP(1995). *The Influence of Type of Residency Training and Gender on an Examination for Medical Licensure.* Paper presented at the Annual Meeting of the American Educational Research Association, April, San Francisco.

Dillon, GF, Henzel TR, and Walsh WP(1996). *The impact of item set configuration on examinee response patterns.* A paper presented at the Annual Meeting of the American Educational Research Association, April, New York.

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Leone-Perkins ML, Dillon GF, Walsh, WP(1996). Examinee perceptions of the usefulness of performance feedback on an examination for medical licensure. Proceedings of the Thirty-fifth Annual Conference of Research in Medical Education. *Academic Medicine*, 1996, 71(10), S88-S90.

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Dillon GF, and Henzel TR(1999). *The relationship between amount of postgraduate training and performance on a physician licensing examination*. A paper presented at the Annual Meeting of the American Education Research Association, April, Montreal.

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